Client ID # (If applicable) _____ Date _____

(INSERT AGENCY NAME)

HIV CASE MANAGEMENT

PHYSICIAN REFERRAL FORM

SUBMIT FORM TO THE HIV CASE MANAGEMENT PROVIDER/AGENCY

COMPLETE THIS FORM AND SEND TO: _____

PHYSICIAN OPTIONS FOR SUBMISSION TO THE HIV CASE MANAGEMENT PROVIDER/AGENCY:
SUBMIT VIA FAX AT: (___) _____
OR SUBMIT VIA MAIL TO: _____
_____
_____

***PHYSICIAN MAY ALSO SUBMIT THE COMPLETED FORM VIA THE CLIENT TO DELIVER TO THE HIV CASE MANAGEMENT PROVIDER IN PERSON.**

CLIENT INFORMATION			
CLIENT NAME:	**DOB:**	**GENDER: MALE ☐ FEMALE ☐ TRANSGENDER ☐**	
RESIDENCE/PERMANENT ADDRESS:	**CITY:**	**COUNTY:**	**ZIP:**
CLIENT PHONE:	**PRIMARY LANGUAGE:**		
EMERGENCY CONTACT NAME:	**RELATIONSHIP:**		
ADDRESS:	**PHONE:**		
IF UNDER 18, NAME OF LEGAL GUARDIAN:	**RELATIONSHIP:**		
ADDRESS:	**PHONE:**		
PROVIDER/AGENCY NAME:	**PROVIDER/AGENCY CONTACT NUMBER:**		
PHYSICIAN/PRACTITIONER NAME:	**FACILITY/PRACTICE NAME:**		
PHYSICIAN/PRACTICTIONER PHONE:	**PHYSICIAN/PRACTICTIONER FAX:**	**PHYSICIAN/PRACTICTIONER E-MAIL:**	

I,_____, RECOMMEND THAT _____ RECEIVE MEDICAID HIV CASE MANAGEMENT SERVICES BASED ON A REVIEW OF THE CLIENT'S MEDICAL RECORDS.

I ATTEST TO THE VALIDITY OF THE POTENTIAL CLIENT'S HIV + STATUS.

_____ _____

PHYSICIAN/PRACTITIONER SIGNATURE **DATE**